Supplemental Life Coverage Continuation Request

RELIASTAR

Instructions

Employer: Complete and sign the unshaded portion of this form. Send this form along with copies of original enrollment form(s) to the employee to complete.

Employee: Complete the shaded portion of this form and return to the address shown below. Be sure to include copies of enrollment form(s) indicating coverage amounts and beneficiary designations as well as your first quarterly premium. **Coverage will not be issued without this information.** We must receive this form within 31 days of the date premium is paid as shown on this form.

This section to be completed by employer

Employee information

Employer or group name	Group number	Account number	AD&D ❒ Yes ❒ No

Employee name	Social Security No.	Date of birth	Date of hire	Preferred rates *(if applicable)* ❒ Yes ❒ No

Employee's coverage amount	Monthly premium	Initial effective date	Date premium paid to	Date payroll deduction terminated	Annual Salary at termination	Children's rider coverage amount

Is direct billing request the result of a disability? ❒ Yes ❒ No

Spouse information (Complete only if insured)

Spouse's name	Social Security No.	Date of birth	AD&D ❒ Yes ❒ No

Spouse's coverage amount	Monthly premium	Initial effective date	Date premium paid to	Date payroll deduction terminated	Children's rider coverage amount	Preferred rates ❒ Yes ❒ No *(if applicable)*

Quarterly Premium Due

Employee's quarterly premium amount:
(Monthly premium x 3 + $3.50 billing charge) $_____

Spouse's quarterly premium amount:
(Monthly premium x 3 + $3.50 billing charge) $_____

Total payment required with this form (Employee + Spouse) $_____

Employer information

Signature of employer representative	Date	Company telephone number

This section to be completed by employee/spouse

Billing address *(Street, city, state, zip)*

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Enclosed with this form is my first quarterly premium made payable to ReliaStar Life. I hereby authorize ReliaStar Life to begin billing me directly for my Supplemental Life Insurance plan.

Date	Signature of insured employee
Date	Signature of insured spouse *(Only if insured)*

Mail to: ReliaStar Life Insurance Company
Route 6971
20 Washington Avenue South
Minneapolis, Minnesota 55401

QUESTIONS? Call Worksite Administration at: 1-800-955-7736.

This section to be completed by ReliaStar Life

Date received	Renewal date	Group number	Certificate number	Date mailed